DEPARTMENT OF CORRECTIONS

Medication Administration Record

Inmate Name: Clacker, Debra

Inmate Number: 159516

Allergies: Codeine

Month: Dec Year: 93

Facility: J.T.P.

Location: [illegible]

CODE: A = ABSENT; R = REFUSED; X = DISCONTINUED

Start / Stop	Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
12/27/93	CTM 4mg tid	6a																												A	h		X
	x 7 days	1p																												A	h		X
1/3/94	Dr. Mendez	6p																											A	A	HM	G	
R.Ph.	Pharmacy Dispensed																																
12/27/93	Sudafed tid	6a																												A	h		X
	x 7 days	1p																												A	h		X
1/3/94	Dr. Mendez	6p																											A	A	HM	G	
R.Ph.	Pharmacy Dispensed																																
12/27/93	Mucolytic tid	6a																												A	h		X
	x 7 days	1p																												A	h		X
1/3/94	Dr. Mendez	6p																											A	A	HM	G	
R.Ph.	Pharmacy Dispensed																																
12/27/93	Throat Lozenges	6a																												A	h		X
	#40 [illegible] x 5 days	1p																												A	h		X
1/1/94	Dr.	6p																											A	A	HM	G	
R.Ph.	Pharmacy Dispensed																																
	Dr.																																
Ph.	Pharmacy Dispensed																																

Signature	Initials	Signature	Initials	Signature	Initials
				[signature]	[initials]
		Sandra Gonzalez	SG	C. Jackson LPN	CJ

F-30-C Clacker, Debra

— PRN Medication and notes on Reverse Side —

PHS0268

DEPARTMENT OF CORRECTIONS

Medication Administration Record

Inmate Name: Clackery Alerra

Inmate Number: 159516

Allergies: Codeine

Month: Nov Year: 93

Facility: J.T.P.

Location: pop

CODE: A = ABSENT; R = REFUSED; X = DISCONTINUED

Start / Stop	Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
10/26/93 / 11/1/93	Pen V.K 500mg i tid x 7 day	6A	EA	X																													
		1P	EA	X																													
	Dr. Anderson	6P	X	X																													
R.Ph.	Pharmacy Dispensed																																
11/2/93	Maalox 30cc bid x 3 day	6A	→	→	EA	A		X																									
	Dr. Mendez	6P	→	W	A	A	x	X																									
R.Ph.	Pharmacy Dispensed																																
11/2/93 / 11/7/93	Tylenol ii bid x 5 day PRN for H/A	6A	→	→	EA	A		(EA)	(R) X																								
	Dr. Mendez	6P	→	W	A	A			x	x																							
R.Ph.	Pharmacy Dispensed																																
	Dr.																																
R.Ph.	Pharmacy Dispensed																																
	Dr.																																
R.Ph.	Pharmacy Dispensed																																

Signature	Initials	Signature	Initials	Signature	Initials
Emma Lewis LPN	JL				

F-30-C Clarkery Alerra — PRN Medication and notes on Reverse Side —

DEPARTMENT OF CORRECTIONS

Medication Administration Record

Inmate Name: Clacker, Debra

Inmate Number: 159516

Allergies: Codeine

Month: Oct Year: 93

Facility: J.T.P.

Location: Pop

CODE: A = ABSENT; R = REFUSED; X = DISCONTINUED

Start / Stop	Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
10/22/93 – 10/25/93	Tylenol tab ii p.o. qid x 5 days; Dr. Menendez	6A																						→	A	A	A	X					
		11A																					→		A	AA		A					
		6P																					→				X	A					
R.Ph.	Pharmacy Dispensed																																
10/25/93 – 10/25/93	Camphophenique to blister & on lip; Dr. Menendez	6P																								→	A	X					
R.Ph.	Pharmacy Dispensed																																
10-26-93 – 11-1-93	Pen VK 500 mg i tid x 7 days; Dr. Anderson	6A																										→	[illegible]	EKA	A	[illegible]	[illegible]
		11A																											[illegible]	[illegible]	[illegible]	[illegible]	A
		6P																										→	GW		Hm		GW
R.Ph.	Pharmacy Dispensed																																
10-26-93 – 10-30-93	Motrin 600 mg i tid x 4 days; Dr. Anderson	6A																										→	[illegible]	EKA	A	[illegible]	
		11A																										→	[illegible]	[illegible]	[illegible]	[illegible]	
		6P																										→	GW		Hm	a	
R.Ph.	Pharmacy Dispensed																																
	Dr.																																
R.Ph.	Pharmacy Dispensed																																

Signature	Initials	Signature	Initials	Signature	Initials

— PRN Medication and notes on Reverse Side —

F-30-C

PHS0270

I

DEPARTMENT OF CORRECTIONS

Inmate Name: Clackler, Debra

Inmate Number: 159516

Allergies: Codeine

Medication Administration Record

Month August Year 93

Facility: Gutwillig

Location: POP

CODE: A = ABSENT; R = REFUSED; X = DISCONTINUED

Start / Stop	Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8-16-93 / 8-19-93	Camphophenique Bid x 3 days.	6A / 6P																															
	Dr. Wilson																																
R.Ph.	Pharmacy Dispensed																																
8-16-93 / 8-21-93	Tylenol tabs #30 p.o. tid PRN x 5 days	6A / 11A / 6P																															
	Dr. Wilson																																
R.Ph.	Pharmacy Dispensed																																
8-16-93 / 8-19-93	Benadryl 25 mg #1 tid x 3 days	6A / 11A / 6P																															
	Dr. Wilson																																
R.Ph.	Pharmacy Dispensed																																
8/17/93	DSW KVO																																
	Dr. Wilson																																
R.Ph.	Pharmacy Dispensed																																
8/17/93	Amcyl I gram IV q6h	12A / 6A / 12N / 6P																															
	Dr. Wilson																																
R.Ph.	Pharmacy Dispensed																																

Signature	Initials	Signature	Initials	Signature	Initials
		[illegible]	OF	[illegible]	KD
		[illegible]	SG		AW

F-30-C

— PRN Medication and notes on Reverse Side —

PHS0271

DEPARTMENT OF CORRECTIONS

Inmate Name: Clarkson, Debra II

Inmate Number: 159510

Allergies: Codeine

Month August Year 93

Facility: Lumberton

Location:

Medication Administration Record

CODE: A = ABSENT; R = REFUSED; X = DISCONTINUED

Start / Stop	Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8/17/93	Motrin 800mg q4-6° prn pain	6a 12n 6p																															
	Dr. Wilson																																
R.Ph.	Pharmacy Dispensed																																
8/20/93 8/23/93	↓ Ancef 1g 50cc i.v. Piggy q8h x 3 days + D/C	12A 6A 12N 6P																															
	Dr. Wilson																																
R.Ph.	Pharmacy Dispensed																																
	Dr.																																
R.Ph.	Pharmacy Dispensed																																
	Dr.																																
R.Ph.	Pharmacy Dispensed																																
	Dr.																																
R.Ph.	Pharmacy Dispensed																																

d/c'd 8/23/93

Signature	Initials	Signature	Initials	Signature	Initials
		Wanda Tenell		K. Clarkson	

— PRN Medication and notes on Reverse Side —

PHS0272

F-30-C

DEPARTMENT OF CORRECTIONS

Medication Administration Record

Inmate Name: Clackler, Debra

Inmate Number: 159516

Allergies: Codeine

Month: July Year: 93

Facility: Tut

Location: pop

CODE: A = ABSENT; R = REFUSED; X = DISCONTINUED

Start / Stop	Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
7-26-93	Hc. Cr. 0.5%	6a																											E				
8-2-93	Bid x 7 days	6p																													A		
R.Ph.	Dr. Wilson Pharmacy Dispensed																																
R.Ph.	Dr. Pharmacy Dispensed																																
R.Ph.	Dr. Pharmacy Dispensed																																
R.Ph.	Dr. Pharmacy Dispensed																																
R.Ph.	Dr. Pharmacy Dispensed																																

Signature	Initials	Signature	Initials	Signature	Initials

— PRN Medication and notes on Reverse Side —

F-30-C

PHS0273

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Clackler, Debra	**Inmate Number:**	159516CL
Service Authorized:	X-Ray: Ultrasound	**Effective Dates:**	11/16/2005
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Tutwiler Prison For Women	**Contact Name:**	Michelle Pope
Authorization Number:	15626621	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: _____ Date _____ Time

Reviewed and Signed By
Medical Director: _____ Date _____ Time

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Must be Complete and Legible. You must Type or P...

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER

Site Phone #: 334-514-6269

Site Fax #: 334-514-9559

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☑ Female

Patient Name: (Last, First,) Clackler, Debra

Alias: (Last, First,) Clackler Debra

Inmate #: 159516

SS Number: 417-80-9985

Date: (mm/dd/yy) 4.16.05

Date of Birth: (mm/dd/yy) 4.26.54

PHS Custody Date: (mm/dd/yy) 08.10.90

Potential Release Date: (mm/dd/yy) 05.23.20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Samuel Engelhardt, M.D.

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy): __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other: Global

Specialist referred to: ultrasound of

Type of Consultation, Treatment, Procedure or Surgery: Pelvis

Diagnosis: abnormal vag. bleeding-DUB

ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

abnormal menstrual bleeding since 4/05; not responding to

Results of a complaint directed physical examination:

provera — uterus N. parous size Need u/s to detect thickened endometrium —

Previous treatment and response (including medications):

provera - not responding

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: __/__/__

GLOBAL DIAGNOSTIC SERVICES
US ~~TV Pelvic~~ ECHO
DATE 12/6/05 INITIALS M. Roy

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class:

CPT code:

UR Auth #: 15626621

05a - UM Referral review form .xls

Ultrasounds done inhouse by Global Diagnostic
M. Moore HSA 11/17/05

PHS0275

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER

Site Phone #: 334-514-6269

Site Fax #: 334-514-9559

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☑ Female

Patient Name: (Last, First) Clackler, Debra

Alias: (Last, First) Clackler Debra

Inmate #: 159576

SS Number: 417809985

Date: (mm/dd/yy) 11/16/05

Date of Birth: (mm/dd/yy) 11/26/54

PHS Custody Date: (mm/dd/yy) 08/10/90

Potential Release Date: (mm/dd/yy) 05/23/20

RECEIVED NOV 17

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Samuel Engelhardt, M.D. [signature]

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

Number of Visits/Treatments: ____

☐ Radiation therapy ☐ Chemotherapy ☑ Other: Global

Specialist referred to: ultrasound

Type of Consultation, Treatment, Procedure or Surgery: Pelvis 0260

Diagnosis: abnormal Vag. bleeding-DUB

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

abnormal menstrual bleeding since 4/05; not responding to

Results of a complaint directed physical examination:

Provera - uterus N. pelvic size Need u/s to detect endometrium -

Previous treatment and response (including medications):

Provera - not responding

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required: [signature] 11/23/05

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Con Type: IIS Mod Code: 26 CPT code: 76856 UR Auth #: 1062662

05a - UM Referral review form

Ultrasounds done inhouse by Global Diagnostic

IO-med approved — M. Moore Hst 11/17/05

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Fo ...ust be Complete and Legible. You must Type or Pr...

Please send this form with the Authorization Letter to the service provider at the ...e of the Appointment

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER	Patient Name: (Last, First,) Clackler, Debra	Date: (mm/dd/yy) 11/16/05
Site Phone # 334-514-6269	Alias: (Last, First,) Clackler Debra	Date of Birth: (mm/dd/yy) 11/26/54
Site Fax # 334-514-9559	Inmate # 15956	PHS Custody Date: (mm/dd/yy) 08/10/90
Will there be a charge? ☑ Yes ☐ No / Sex ☐ Male ☑ Female	SS Number 417-80-9985	Potential Release Date: (mm/dd/yy) 05/23/20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Samuel Engelhardt, M.D. [signature]

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

History of illness/injury/sypmtoms with Date of Onset:
abnormal menstrual bleeding since 4/05; not responding to

Results of a complaint directed physical examination:
Provera — uterus nl. parous size Need u/s to detect thickened endometrium —

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other: Global

Number of Visits/Treatments: ____

Specialist referred to: ultrasound of

Type of Consultation, Treatment, Procedure or Surgery: Pelvis

Diagnosis: abnormal vag. bleeding-DUB

ICD-9 code:

Previous treatment and response (including medications):
provera - not responding

FAXED 11/17/05 BR

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

Date resubmitted: __/__/__

☐ Resubmitted with requested information.

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

Ultrasounds done inhouse by Global Diagnostic

PHS0277

MONTGOMERY SURGICAL ASSOCIATES, P.A.
2055 EAST SOUTH BLVD., SUITE 603
MONTGOMERY, AL 36116
(334) 281-9000
1-800-886-1231

Insurance and billing inquiries only
Phone (334) 281-9730
TAX I.D. 63-0634673

L... COMATES, AMERICAN BOARD OF SURGERY
GENERAL AND PERIPHERAL VASCULAR SURGERY

151631

GUARANTOR NAME AND ADDRESS	PATIENT NO.	PATIENT NAME	DOCTOR NO.	DATE
DEBRA CLACKER 8966 US HWY 231 WETUMPKA AL 36092	106394	DEBRA CLACKER	7	07/13/05

DATE OF BIRTH	TELEPHONE NUMBER	INSURANCE CODE	INSURANCE DESCRIPTION	INSURANCE CERTIFICATE NO.
50 FEMALE 11/26/54	000-0000	2161	RISON HEALT	47809985

OFFICE VISITS

NEW		ESTABLISHED	
		BRIEF	99211
BRIEF	99201	LIMITED	99212
LIMITED	99202	INTERMED	99213
INTERMED	99203	EXTENDED	99214
EXTENDED	99204	COMPREH	99215
COMPREH	99205		
SURG PRO	99025	NO CHARGE	99024

CONSULTATIONS NEW & ESTAB.		SECOND OPINIONS NEW & ESTAB.	
LIMITED	99241	LIMITED	99271
INTERMED	99242	INTERMED	99272
EXTENDED	99243	EXTENDED	99273
COMPREH	99244	COMPREH	99274
COMPLEX	99245	COMPLEX	99275

DEBRIDEMENT - SKIN

PARTIAL THICKNESS	11040
FULL THICKNESS	11041

FOREIGN BODY REMOVAL

*SKIN, SIMPLE	10120
SKIN, COMPLICATED	10121
*MUSCLE, SUPERFICIAL	20520
ANAL W/ANOSCOPY	46608

HEMORRHOIDS

INCISION-THROMBOSED	46083
BANDING-SIMPLE	46221
EXCISION-EXTERNAL TAG	46230
EXCISION-THROMBOSED	46083

INCISION & DRAINAGE

*CYST/ABSCESS - SIMPLE	10060
CYST/ABSCESS - COMPLEX	10061
*PILONIDAL - CYST - SIMPLE	10080
PILONIDAL - COMPLICATED	10081
*HEMATOMA - SIMPLE	10140
*POSTOPERATIVE WOUND	10160
*PERINEAL ABSCESS	56405
*PERIANAL ABSCESS	46050

BREAST PROCEDURES

*CYST ASPIRATION (1)	19000
EACH ADDL CYST	19001
*NEEDLE BIOPSY	19100
MASS EXCISION	19120

BIOPSIES

SKIN/SUBCUTANEOUS	11100
SKIN/SUBCUT - EACH ADDL	11101
*BREAST - NEEDLE	19100
MUSCLE SUPERFICIAL	20200
*MUSCLE-NEEDLE	20206
*THYROID NEEDLE	60100

PROCTOSCOPY & ANOSCOPY

PROCTOSCOPY	45300
PROCTOSCOPY W/BIOPSY	45305
PROCTOSCOPY W/DILATION	45303
ANOSCOPY	46600
ANOSCOPY W/DILATION	46604
ANOSCOPY W/BIOPSY	46606

NAIL PROCEDURES

*DEBRIDEMENT 1-5	11700
DEBRIDEMENT ea addl 5	11701
*NAIL REMOVAL (1st)	11730
NAIL REMOVAL (2nd)	11731
NAIL REMOVAL (ea over 2)	11732
SUBUNGAL, HEMATOMA EVAC	11740
*PARONYCHIA	10060

SIMPLE SKIN REPAIR

TRUNK, SCALP, EXTREMITIES	
*0.1cm-2.5cm	12001
*2.6cm-7.5cm	12002
*7.6cm-12.5cm	12004
over 12.5cm	
FACE, HANDS, FEET	
*0.1cm-2.5cm	12011
*2.6cm-7.5cm	12013
*7.6cm-12.5cm	12014
over 12.5cm	

MISCELLANEOUS PROCEDURES

UNNA BOOT	29580
CHG GAST/TUBE	43760
MED REC/RPT	99080
MED TESTIMONY	99075

INJECTIONS

TETANUS TOXOID	90703
NERVE INJECTION	64425
JOINT INJECTION/ASPIRATION	20605
TRIGGER/FINGER	20550

OTHER

I & D PERINEAL ABCESS	56405
I & D PERIANAL ABCESS	46050
CATH/PORT REMOVAL	36535

OTHER

RETURN TO DOCTOR

____ WEEKS ____ MONTH(S) ____ YEAR(S)
PRN

DIAGNOSIS ICD 9

HOSP PROC/DX IN/OUT B BSC JXN MSC EM

ADM DT __/__/__
SURG DT __/__/__

REFERRING PHYSICIAN

SAMUEL ENGLEHARDT MD

EXCISIONS-BENIGN SKIN LESIONS

TRUNK & EXTREMITIES		SCALP, NECK, HANDS, FEET		FACE & EARS	
Size	1140	Size	1142	Size	1144

SHAVING-LESIONS

TRUNK & EXTREMITIES		SCALP, NECK, HANDS, FEET		FACE & EARS	
Size	1130	Size	1130	Size	1131

ULTRASOUND GUIDED PROCEDURES

DIAGNOSTIC ULTRASOUND, BREAST	76645

ULTRASOUND GUIDED NEEDLE BREAST BIOPSY

U/S GUIDANCE, NEEDLE CORE	76942
NEEDLE CORE BIOPSY	19100
ADDITIONAL NEEDLE CORE BIOPSY	19100

DIAGNOSTIC ULTRASOUND, THYROID	76536

ULTRASOUND GUIDED NEEDLE THYROID BIOPSY

U/S GUIDANCE, NEEDLE CORE	76942
NEEDLE CORE BIOPSY	60100

TEMPORAL ARTERY BIOPSY	37609

ULTRASOUND GUIDED BREAST CYST ASPIRATION

U/S GUIDANCE, CYST ASPIRATION	76938
CYST ASPIRATION	19000
ADDITIONAL CYST ASPIRATIONS	19001

ULTRASOUND GUIDED THYROID CYST ASPIRATION

U/S GUIDANCE, CYST ASPIRATION	76938
THYROID CYST ASPIRATION	60001

151804 39

DATE OF LAST PAYMENT		
	INSURANCE	PATIENT
PREVIOUS BALANCE	705.00	.00
TODAY'S CHARGES		
PAID ON ACCOUNT		
ADJ. CHECK CASH		
TOTAL DUE		

RELEASE, ASSIGNMENT AND RESPONSIBILITY ( )
I hereby authorize the undersigned Physician to release ar information acquired in the course of my child's examinatic or treatment. I also authorize payment directly to th undersigned physician of the surgical and/or medic benefits. It is understood that any monies received from th insurance company over and above my indebtedness will t refunded to me when bill is paid in full. I understand that I a financially responsible for any collection fees, attorney fee or court costs should my account become delinquent.

(X) ____
Signed

PHS0278

ate

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Must be Complete and Legible. You must type or P
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER

Site Phone #: 334-514-6269

Site Fax #: 334-514-9559

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☑ Female

Patient Name: (Last, First,) Clacker, Debra

Alias: (Last, First,)

Inmate # 159576

SS Number 417-80-9985

Date: (mm/dd/yy) 06/24/05

Date of Birth: (mm/dd/yy) 11/26/54

PHS Custody Date: (mm/dd/yy) 8/10/90

Potential Release Date: (mm/dd/yy) 5/23/20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Winfred Williams, M.D.

Facility Medical Director Signature and Date: 6/27/05

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:_____

Specialist referred to: Dr Daly

Type of Consultation, Treatment, Procedure or Surgery:
F/u Lipoma Resection
in 2wks

Diagnosis: Lipoma
ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:
Lipoma Resection 6/25/05
(L) Abd

Results of a complaint directed physical examination:
Post op dsg w/d
Needs F/u Appt.

Previous treatment and response (including medications):
Lipoma Resection

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

6/28/

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

05a - UM Referral review form Dr. Dan Daly with Montgomery Surgical Associates

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

RECEIVED JUN 28 2005

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER

Site Phone #: 334-514-6269

Site Fax #: 334-514-9559

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☑ Female

Patient Name: [Last, First] Clacker, Debora

Alias: [Last, First]

Inmate #: 159576

SS Number: 417-80-9985

Date: [mm/dd/yy] 06/27/05

Date of Birth: [mm/dd/yy] 11/26/54

PHS Custody Date: [mm/dd/yy] 8/10/90

Potential Release Date: [mm/dd/yy] 5/23/20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services)

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Winfred Williams, M.D.

Facility Medical Director Signature and Date: 6/27/05

☐ Service meets criteria for "approval-via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ other ____

Specialist referred to: Dr Daly

Type of Consultation, Treatment, Procedure or Surgery:

F/u Lipoma Resection
in 2wks

Diagnosis: Lipoma

ICD-9 code: 214.1

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

Lipoma Resection 4/25/05

(L) Abd

Results of a complaint directed physical examination:

Post op day well
Needs F/u Appt.

Previous treatment and response (including medications):

Lipoma Resection

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☐ Offsite Service Recommended and Authorized

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

Will Mosier, MD 6/28/05

Do not write below this line. For Case Manager and Corporate Data Entry ONLY

Cont Type: FU OV Med Class:

CPT code: 99024

UR Auth #: 1480439

05a - UM Referral review form

Dr. Dan Daly with Montgomery Surgical Associates

PHS0280

%

B0517400344 CLACKLER,DEBRA J
DOB: 11/26/54 Age:50Y MR #:180437
Admit Date/Time: 06/24/05 0807A
271 DALY,DANIEL M

Patient Information

Baptist Health

PHYSICIAN'S ORDERS

Height:________ Weight:________

Drug Sensitivities and Allergies ❑ NKDA ❑ Yes, list: ________

DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE
'u' or 'U'	Unit	MS, MSO4 MgSO4	Spell out words	TIW	Spell out words	Per os or OS	Spell out by mouth/oral
IU	International Unit	.Xmg	0.Xmg	µg	microgram	BT	Spell out Bedtime
QD/QOD	Spell out words	X.0 mg	'X' mg	AD, AS, AU	Spell out words	QN or qn	Spell Out Nightly or at Bedtime

Date	Time	
6-24-5		TO ARD out patient
		D/C dressing in
		24 hrs
		may get wet in 24°
		f/up 2-3 weeks
		Tylenol #3 T-TT
		q4h prn pain

Physician Signature: PHS0281

PH 350

DO NOT WRITE BELOW THIS LINE

Form #PH 35001 Revised 3/24/04

NOTICE OF PRIVACY PRACTICES OF BAPTIST HEALTH AND ITS' AFFILIATED CORPORATIONS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE

BAPTIST. This Notice describes the privacy practices of Baptist Health and all of its programs and departments, including Baptist Medical Center South, Baptist Medical Center East, Prattville Baptist Hospital; and its' affiliated corporations Montgomery Baptist Outreach Services, d/b/a Montgomery Family Medicine Residency Program; Baptist Ventures Inc., d/b/a Montgomery Surgery Center, Baptist Tower Pharmacy, and the five Primed locations; and Health Insurance Corporation of Alabama, all collectively referred to as "Baptist".

MEDICAL STAFF. This Notice also describes the privacy practices of an "organized health care arrangement" or "OHCA" between Baptist and eligible providers on its' Medical Staffs. Because Baptist is a clinically-integrated care setting, our patients receive care from Baptist staff and from indepedent practioners on the Medical Staffs. Baptist and its' Medical Staffs must be able to share your medical information freely for treatment, payment and health care operations as described in this Notice. Because of this, Baptist and all eligible providers on the Hospital' and other entities' Medical Staffs have entered into the OHCA under which Baptist and the eligible providers will:

- Use this Notice as a joint notice of privacy practices for all inpatient and outpatient provision of medical care and follow all information practices described in this notice;
- Obtain a single signed acknowledgement of receipt; and
- Share medical information from inpatient and outpatient provision of medical care with eligible providers so that they can help Baptist with its' health care operations.

The OHCA does not cover the information of practices of practioners in their private offices or at other practive locations.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The following are the types of uses and disclosures we may make of your medical information without your permission. Medical information includes items such as your diagnosis, medications, medical history, and insurance payment information, which identifies you. Where State or federal law restricts one of the described uses or disclosures, we follow the requirements of such State or federal law. These are general descriptions only. They do not cover every example of disclosure within a category.

Treatment. We will use and disclose your medical information for treatment. For example, we will share medical information about you with our nurses, your physician and others who are involved in your care at Baptist. We will also disclose your medical information to your physician and other practioners, providers and health care facilities for their use in treating you in the future. For example, if you are transferred to a nursing facility,we will send medical information about you to the nursing facility.

Payment. We will use and disclose your medical information for payment purposes. For example, we will use your medical to prepare your bill and we will send medical information to your insurance company with your bill. We may also disclose medical information about you to other medical care providers, medical plans and health care clearinghouses for their payment purposes. For example, if you are brough in by ambulance, the information collected will be given to the ambulance provider for it billing purposes. If State law requires, we will obtain your permission prior to disclosing to other providers or health insurance companies for payment purposes.

Health Care Operations. We may use or disclose your medical information for our health care operations. For example, medical staff memebers may review your medical information to evaluate the treatment and services provided, and the performance of our staff in caring for you. In some case, we will furnish other qualified parties with you medical information for their health care operations. The ambulance company, for example, may also want information on your condition to help them know whether they have done an effective job of providing care. If State law requires, we will obtain your permission prior to disclosing to other providers or health insurance companies for their operations.

Business Associates. We will disclose your medical information to our business associates and allow them to create, use and disclose your medical information to perform their job. For example, we may disclose your medical information to an outside billing company who assists us in billing insurance companies.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical services.

Treatment Alternatives. We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising. We may contact you as part of a fundraising effort. We also disclose certain elements of your medical information, such as your name, address, phone number and dates you received treatment or services, to a business associate or a foundation related to Baptist so that they may contact you to raise money for Baptist. If you do not wish to be contacted regarding fundraising, please contact the Baptist Health Care Foundation at 334-273-4567, or mail your request to Baptist Health Care Foundation, P.O. Box 241647, Montgomery, Alabama 36124-1647.

Facility Directory. We may include your name, location in the facilty, general condition and religious affiliation in a facility directory. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. We will not include your information in the facility directory if you object or if we are prohibited by State or federal law.

Family and Friends. We may disclose your location or general condition to a family member or your personal representative. If any of these individuals or others you identify are involved in your care, we may also disclose such information as is directly relevant to their involvement. We will only release this information if you agree, are given the opportunity to object and do not, or if in our proffesional judgement, it would be in your best interest to allow the person to receive the information or act on your behalf. For example, we may allow a family member to pick up your prescriptions, medical supplies or X-rays. We also may disclose your information to an entity assisting in disaster relief efforts so that your family or individual responsible for your care may be notified of your location and condition.

Required by Law. We will use and disclose your information as required by federal, State or local law.

Public Health Activities. We may disclose medical information about you for public health activities. These activities may include disclosures:

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability;
- To appropriate authorities authorized to receive reports of child abuse and neglect;
- To FDA-regulated entities for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect or Domestic Violence. We may notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. Unless such disclosure is required by law, we will only make this disclosure if you agree.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliances with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administratvie order. We may also disclose medical information about you in response to a subpeona, discovery request or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request or to obtain an order from the court protecting the information requested.

Law Enforcement. We may release certain medical information if asked to do so by law enforcement official:

- As required by law, including reporting wounds and physical injuries;
- In response to a court order, subpeona, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if we obtain the individual's agreement or, under certain limited circumstances if we are able to obtain the individual's agreement;
- To alert authorities of a death we believe may be the result of criminal conduct;
- Information we believe is evidence of criminal conduct occuring on our premises; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Deceased Individuals. We may release medical information to a coroner, medical examiner or funeral director as necessary for them to carry out their duties.

Organ, Eye or Tissue Donation. We may release medical information to organ, eye or tissue procurement, transplantation or banking organizations or entities as necessary to facilitate organ, eye or tissue donation and transplantation.

Research. Under certain circumstances we may use or disclose your medical information for research, subject to certain safeguards. For example, we may disclose information to researchers when their research has been approved by a special committee that has reviewed the research proposal and established protocols to ensure the privacy of your medical information. We may disclose medical information about you to people preparing to conduct a research project, but the information will stay on-site.

Threats to Health or Safety. Under certain circumstances, we may use or disclose your medical information to avert a serious threat to health and safety if we, in good faith, believe the use or disclosure is necessary to prevent or lessen the threat and is to a person reasonably able to prevent or lessen the threat (including the target) or is necessary for law enforcement to identify or apprehend an individual involved in a crime.

Specialized Government Functions. We may use and disclose your medical information for national security and intelligence activities authorized by law or for protective services of the President. If you are a military member, we may disclose to military authorities under certain circumstances. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may dosclose to the institution, its agents or the law enforcement official your medical information necessary for your health and the health and safety of other individuals.

Workers' Compensation. We may release medical information about you as authorized by law for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Incidental Uses and Disclosures. There are certain incidental uses or disclosures of your information that occur while we are providing service to you or conduction out business. For example, after surgery the nurse or doctor may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

Other Uses and Disclosures. Other uses and disclosure of your medical information not covered above will be made only with your written permission. If you authorize us to use and disclose your information, you may revoke that authorization at any time. Such revocation will not affect any action we have taken in reliance on your authorization.

INDIVIDUAL RIGHTS

Request for Voluntary Restrictions. You have the right to request a restriction on how we use and disclose your medical information for treatment, payment and health care operations, or to certain family members or friends identified by you who are involved in your care or the payment for your care. We are not required to agree to your request, and will notify you if we are unable to agree.

Access to Medical Information. You may request to inspect and copy much of the medical information we maintain about you, with some exceptions. If you request copies, we will charge you a copying fee plus postage.

Amendment. You may request that we amend certain medical information that we keep in your records. We are not required to make all requested amendments but will give each request careful consideration. If we deny your request, we will provide you with a written explanation of the reasons and your rights.

Accounting. You have the right to receive an accounting of certain disclosures of your medical information made by us or our business associates. The first accounting in any 12-month period is free; you may be charged a fee for each subsequent accounting you request within the same 12-month period.

Confidential Communications. You may request that we communicate with you about your medical information in a certain way or at a certain location. We must agree to your request if it is reasonable and specifies the alternate means or locations.

How to Exercise These Rights. All requests to exercise these rights must be in writing. We will follow written policies to handle requests and notify you of our decision or actions and your rights. For more information or to obtain request forms, please contact the Privacy Office as indicated below.

ABOUT THIS NOTICE

We are required to follow the terms of the Notice currently in effect. We reserve the right to change our practices and the terms of this Notice and to make new practices and notice provisions effective for all medical information that we maintain. Before we make such changes effective, we will make available. The revised Notice will also be posted on our website at **www.baptistfirst.org.** You are entitled to receive thie Notice in written form. Please contact the Privacy Officer at the address listed below to obtain a written copy.

COMPLAINTS

If you have concerns about any of our privacy practices or believe that your privacy rights have been violated, you may file a complaint with Baptist using the contact information at the end of this Notice. You may also submit a written complaint to Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta GA 30303-8909. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

Privacy Officer
Baptist Health
301 Brown Springs Road
Montgomery, Alabama 36117

tel 334-273-4417
fax 334-273-4415

Mailing Address:
PO Box 244001
Montgomery, Alabama 36124-4001

NPP1

EFFECTIVE DATE: April 14, 2003

MANAGEMENT REFERRAL [illegible] FORM

must be Complete and Legible [illegible] Authorization Letter to the service provider [illegible]

PHS

RECEIVED JUN 21 2005

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER
Site Phone #: 334-514-6289
Site Fax #: 334-514-9559
Will there be a charge? ☑ Yes ☐ No
Sex: ☐ [illegible]

Patient Name: (Last, First): Clackler, Debra
Alias: (Last, First): Clackler Debra
Inmate #: 159616
SS Number: 417-80-9985

Date: (mm/dd/yy): 6/20/05
Date of Birth: (mm/dd/yy): 11/26/54
PHS Custody Date: (mm/dd/yy): 8/10/90
Potential Release Date: (mm/dd/yy): 5/23/20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental
Samuel Engelhardt, M.D.

Facility Medical Director Signature and Date: [signature] 3/16/05

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☑ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DX)
☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy): __/__/__
(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other:
Number of Visits/Treatments: ____

Specialist referred to: Elmore Community Hosp.

Type of Consultation, Treatment, Procedure or Surgery: Mammogram

Diagnosis:
ICD-9 code: V76.10

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/Injury/symptoms with Date of Onset: > 40 annual mammo

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):
☐ More Information Requested (See Attached)
☐ Resubmitted with requested information.
☑ Offsite Service Recommended and Authorized

Date re-submitted: __/__/__

Regional Medical Director Signature printed name: Wm. Moser, MD [signature] 6/21/5 (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cost Type: MM Med Class: XR CPT code: 76091 UR Auth #: 15160225

05a - UM Referral review form

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER

Site Phone #: 334-514-6269

Site Fax #: 334-514-9559

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☑ Female

Patient Name: (Last, First,) Clackler, Debra

Alias: (Last, First,) Clackler Debra

Inmate #: 159576

SS Number: 417-80-9985

Date: (mm/dd/yy) 4/20/05

Date of Birth: (mm/dd/yy) 11/26/54

PHS Custody Date: (mm/dd/yy) 8/10/90

Potential Release Date: (mm/dd/yy) 5/23/20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare; Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Samuel Engelhardt, M.D.

Facility Medical Director Signature and Date: 3/16/05

☐ Service meets criteria for "approval via protocol"

History of illness/injury/sypmtoms with Date of Onset:

> 40 annual mammo

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☑ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:

Specialist referred to: Elmore Community Hosp.

Type of Consultation, Treatment, Procedure or Surgery:

Mammogram

Diagnosis:

ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

4/21/05

PHS

PRISON HEALTH SERVICES, INC.

FACSIMILE TRANSMITTAL SHEET

TO: Dr Mosier	FROM: *BARBARA @ TUTWILER (SITE 844)*
COMPANY:	DATE: 5/23/05
FAX NUMBER: 395-8156	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER:	SENDERS PHONE (334) 514-6269
RE:	SENDERS FAX (334) 514-9559

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

If you receive this in error, please call Barbara at 334-514-6269. Thank you.

TRANSMISSION VERIFICATION REPORT

TIME : 05/23/2005 13:42
NAME : TUTWILER
FAX : 3345149559
TEL : 3345146269

DATE,TIME	05/23 13:40
FAX NO./NAME	3958156
DURATION	00:01:10
PAGE(S)	03
RESULT	OK
MODE	STANDARD ECM

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

RECEIVED MAY 18 2005

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER

Site Phone #: 334-514-6269

Site Fax #: 334-514-9559

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☑ Female

Patient Name: (Last, First,) Clackler, Debra

Alias: (Last, First,) Clackler Debra

Inmate #: 159516 159516

SS Number: 417-80-9985

Date: (mm/dd/yy) 5,12,05

Date of Birth: (mm/dd/yy) 11,26,54

PHS Custody Date: (mm/dd/yy) 08,10,90

Potential Release Date: (mm/dd/yy) 5,23,20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Samuel Engelhardt, M.D.

Facility Medical Director Signature and Date: Engelhardt

☐ Service meets criteria for "approval via protocol"

History of illness/injury/symptoms with Date of Onset:

Large lipoma abd wall - two years

Results of a complaint directed physical examination:

Surgeon who can remove

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☒ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other: ____

Specialist referred to: Dr Daly

Type of Consultation, Treatment, Procedure or Surgery:

Excision lipoma - abd wall

Previous treatment and response (including medications):

6 cm

Diagnosis: lipoma

ICD-9 code:

You must include copies of pertinent reports such as lab results, xray interpretations and specialty consult reports with this form.

☒ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☒ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☐ Offsite Service Recommended and Authorized

Need Records

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and title: Will Mosier, MD

5,20,05 (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class:

CPT code:

UR Auth #:

*06a - UM Referral review form

Dr. Dan Daly with Montgomery Surgical Associates

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER

Site Phone #: 334-514-6269

Site Fax #: 334-514-9559

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☑ Female

Patient Name: (Last, First,) Clackler, Debra

Alias: (Last, First,) Clackler Debra

Inmate #: 159516 159516

SS Number: 417-80-9985

Date: (mm/dd/yy) 5/2/01

Date of Birth: (mm/dd/yy) 11/26/54

PHS Custody Date: (mm/dd/yy) 08/10/90

Potential Release Date: (mm/dd/yy) 5/23/20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Samuel Engelhardt, M.D.

Facility Medical Director Signature and Date: Engelhardt

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☒ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to: Dr Daly

Type of Consultation, Treatment, Procedure or Surgery: EXCISION lipoma abd wall

Diagnosis: lipoma

ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☑ Pertinent Documents have been attached and faxed.

History of Illness/injury/sypmtoms with Date of Onset: Large lipoma abd wall - has been

Results of a complaint directed physical examination: Surgeon who rec. removal

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class:

CPT code:

UR Auth #:

05a - UM Referral review form

Dr. Dan Daly with Montgomery Surgical Associates

5/18/01 BK

MONTGOMERY SURGICAL ASSOCIATES, P.A.
555 EAST SOUTH BLVD., SUITE 603
MONTGOMERY, AL 36116
(334) 281-9000
1-800-886-1231

Insurance and billing inquiries only
Phone (334) 281-9730
TAX I.D. 63-0634673

FELLOWS, AMERICAN BOARD OF SURGERY
GENERAL AND PERIPHERAL VASCULAR SURGERY

150165

GUARANTOR NAME AND ADDRESS	PATIENT NO.	PATIENT NAME	DOCTOR NO.	DATE
DEBRA CLACKER 8966 US HWY 231 WETUMPKA AL 36092	106394	DEBRA CLACKER	7	05/16/05

DATE OF BIRTH	TELEPHONE NUMBER	INSURANCE CODE	INSURANCE DESCRIPTION	INSURANCE CERTIFICATE NO.
50 FEMALE 11/26/54	000-0000	2161	PRISON HEALT	417809985

OFFICE VISITS

NEW		ESTABLISHED	
		BRIEF	99211
BRIEF	99201	LIMITED	99212
LIMITED	99202	INTERMED	99213
INTERMED	99203	EXTENDED	99214
EXTENDED	99204	COMPREH	99215
COMPREH	99205		
SURG PRO	99025	NO CHARGE	99024

CONSULTATIONS NEW & ESTAB.		SECOND OPINIONS NEW & ESTAB.	
LIMITED	99241	LIMITED	99271
INTERMED	99242	INTERMED	99272
EXTENDED	99243	EXTENDED	99273
COMPREH	99244	COMPREH	99274
X COMPLEX	99245	COMPLEX	99275

DEBRIDEMENT - SKIN

PARTIAL THICKNESS	11040
FULL THICKNESS	11041

FOREIGN BODY REMOVAL

*SKIN, SIMPLE	10120
SKIN, COMPLICATED	10121
*MUSCLE, SUPERFICIAL	20520
ANAL W/ANOSCOPY	46608

HEMORRHOIDS

INCISION-THROMBOSED	46083
BANDING-SIMPLE	46221
EXCISION-EXTERNAL TAG	46230
EXCISION-THROMBOSED	46083

INCISION & DRAINAGE

*CYST/ABSCESS - SIMPLE	10060
CYST/ABSCESS - COMPLEX	10061
*PILONIDAL - CYST - SIMPLE	10080
PILONIDAL - COMPLICATED	10081
*HEMATOMA - SIMPLE	10140
*POSTOPERATIVE WOUND	10160
*PERINEAL ABSCESS	56405
*PERIANAL ABSCESS	46050

BREAST PROCEDURES

*CYST ASPIRATION (1)	19000
EACH ADDL CYST	19001
*NEEDLE BIOPSY	19100
MASS EXCISION	19120

EXCISIONS-BENIGN SKIN LESIONS

TRUNK & EXTREMITIES — Size _____ 1140

SCALP, NECK, HANDS, FEET — Size _____ 1142

FACE & EARS — Size _____ 1144

SHAVING-LESIONS

TRUNK & EXTREMITIES — Size _____ 1130

SCALP, NECK, HANDS, FEET — Size _____ 1130

FACE & EARS — Size _____ 1131

ULTRASOUND GUIDED PROCEDURES

DIAGNOSTIC ULTRASOUND, BREAST	76645

ULTRASOUND GUIDED NEEDLE BREAST BIOPSY

U/S GUIDANCE, NEEDLE CORE	76942
NEEDLE CORE BIOPSY	19100
ADDITIONAL NEEDLE CORE BIOPSY	19100

DIAGNOSTIC ULTRASOUND, THYROID	76536

ULTRASOUND GUIDED NEEDLE THYROID BIOPSY

U/S GUIDANCE, NEEDLE CORE	76942
NEEDLE CORE BIOPSY	60100
ADDITIONAL NEEDLE CORE BIOPSY	60100

TEMPORAL ARTERY BIOPSY	37609

ULTRASOUND GUIDED BREAST CYST ASPIRATION

U/S GUIDANCE, CYST ASPIRATION	76936
CYST ASPIRATION	19000
ADDITIONAL CYST ASPIRATIONS	19001

ULTRASOUND GUIDED THYROID CYST ASPIRATION

U/S GUIDANCE, CYST ASPIRATION	76936
THYROID CYST ASPIRATION	60001

BIOPSIES

SKIN/SUBCUTANEOUS	11100
SKIN/SUBCUT - EACH ADDL	11101
*BREAST - NEEDLE	19100
MUSCLE SUPERFICIAL	20200
*MUSCLE-NEEDLE	20206
*THYROID NEEDLE	60100

PROCTOSCOPY & ANOSCOPY

PROCTOSCOPY	45300
PROCTOSCOPY W/BIOPSY	45305
PROCTOSCOPY W/DILATION	45303
ANOSCOPY	46600
ANOSCOPY W/DILATION	46604
ANOSCOPY W/BIOPSY	46606

NAIL PROCEDURES

*DEBRIDEMENT 1-5	11700
DEBRIDEMENT ea addl 5	11701
*NAIL REMOVAL (1st)	11730
NAIL REMOVAL (2nd)	11731
NAIL REMOVAL (ea over 2)	11732
SUBUNGAL, HEMATOMA EVAC	11740
*PARONYCHIA	10060

SIMPLE SKIN REPAIR

TRUNK, SCALP, EXTREMITIES

*0.1cm-2.5cm	12001
*2.6cm-7.5cm	12002
*7.6cm-12.5cm	12004
over 12.5cm	

FACE, HANDS, FEET

*0.1cm-2.5cm	12011
*2.6cm-7.5cm	12013
*7.6cm-12.5cm	12014
over 12.5cm	

MISCELLANEOUS PROCEDURES

UNNA BOOT	29580
CHG GAST/TUBE	43760
MED REC/RPT	99080
MED TESTIMONY	99075

REFERRING PHYSICIAN

SAMUEL ENGLEHARDT MD

INJECTIONS

TETANUS TOXOID	90703
NERVE INJECTION	64425
JOINT INJECTION/ASPIRATION	20605
TRIGGER/FINGER	20550

OTHER

I & D PERINEAL ABCESS	56405
I & D PERIANAL ABCESS	46050
CATH/PORT REMOVAL	36535

OTHER

RETURN TO DOCTOR

_____ WEEKS _____ MONTH(S) _____ YEAR(S)
_____ PRN

DIAGNOSIS Lt ICD 9 Lt Arm 5 cm

HOSP PROC/DX IN/OUT B BSC JXN MSC EM

_____ ADM DT __/__/__
_____ SURG DT __/__/__

Ref # 14906 57

DATE OF LAST PAYMENT Unmade

	INSURANCE (01)	PATIENT (0
PREVIOUS BALANCE		
TODAY'S CHARGES		
PAID ON ACCOUNT		
ADJ. CHECK CASH		
TOTAL DUE		

RELEASE, ASSIGNMENT AND RESPONSIBILITY (
hereby authorize the undersigned Physician to release a
information acquired in the course of my child's examinat
or treatment. I also authorize payment directly to
undersigned physician of the surgical and/or medi
benefits. It is understood that any monies received from
insurance company over and above my indebtedness will
refunded to me when bill is paid in full. I understand that I
financially responsible for any collection fees, attorney fe
or court costs should my account become delinquent.

(X) _____
Signed

PHS0293

_____
tle

Montgomery Surgical Associates, P.A.

www.montgomerysurgical.com

Duncan B. McRae, Jr., MD, FACS
Alex V. Kreher, Jr., MD, FACS
Daniel M. Daly, MD, FACS
Robert B. Harris, MD, FACS

Jimmy Norman, CPA Administrator

May 16, 2005

Dr. Samuel Engelhardt
Julia Tutwiler Prison
Health Care Unit
8966 US Highway 231
Wetumpka, AL 36092

RE: Debra Clackler

Dear Dr. Engelhardt:

I saw Debra Clackler in the office today for evaluation of a couple of problems. I told her I would take care of the left flank lipoma with excision of this as an outpatient. Her right-sided abdominal pain seems to originate just above the umbilicus and radiate toward the right abdomen and right flank. She has an area that is tender just above the umbilicus. I suspect she may have a small incisional hernia at the bottom of her cholecystectomy scar. However, I was unable to definitely detect a hernia. I told her I would explore the area or proceed with a hernia repair only if she developed a clinically detectable hernia. I told her I would like to see her back again in a few months to reexamine the area.

Thank you for allowing me to be of assistance in the care of Ms. Clackler.

Sincerely,

Daniel M. Daly, M.D.

DMD/mpf

PHS0294

Baptist South Office
2055 E. South Blvd., Suite 603
Montgomery, AL 36116-2463
(334) 281-9000
Fax (334) 281-8262

Baptist East Office
440 Taylor Road, Suite 3380
Montgomery, AL 36117
(334) 409-9683
Fax (334) 409-9258

Prattville Office
645 McQueen Smith Rd, Ste 102
Prattville, AL 36066
(334) 361-0711
Fax (334) 358-0370

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Clackler, Debra	**Inmate Number:**	159516CL
Service Authorized:	Office Visits: General Surgery Consult	**Effective Dates:**	04/12/2005
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Tutwiler Prison For Women	**Contact Name:**	Michelle Pope
Authorization Number:	14906957	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

large lipoma left flank
old pain originate from
just above umbilicus & laterally
to AT flank - [illegible] small hernia
Plan - excise lipoma
- F/U in a few months for umbil hernia

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: Date 5-16-05 Time

Reviewed and Signed By Medical Director: Date 5/17/05 Time

04/14/2005

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER

Site Phone #: 334-514-5269

Site Fax #: 334-514-5559

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☑ Female

Patient Name: (Last, First): Clackley, Debra

Alias: (Last, First): Clackler Debra

Inmate #: 159516

SS Number: 417-80-9985

Date: (mm/dd/yy): 04.12.05

Date of Birth: (mm/dd/yy): 11.26.55

PHS Custody Date: (mm/dd/yy): 08.10.90

Potential Release Date: (mm/dd/yy): 05.23.20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

John Peasant, M.D.

Facility Medical Director Signature and Date: [signature]

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☑ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other:

Number of Visits/Treatments: ____

Specialist referred to: DR Daly

Type of Consultation, Treatment, Procedure or Surgery: Evaluation of Bilat acute pain, and (R) side lipoma

Diagnosis: (R) side lipoma

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/Injury/Symptoms with Date of Onset: 50 y/o c/o Bilat acute pain. She S/P. Cholecystectomy.

Results of a complaint directed physical examination: (R) side lipoma - Positive tenderness 214

Previous treatment and response (including medications): Obs and f/u Tylenol tab.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☑ More Information Requested: (See Attached) ABD U.S? CT ABD?

☐ Resubmitted with requested information. Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date Required: Will Mosier, MD [signature] 4/14/05 (mm/dd/yy)

Do Not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: GS | Misc Class: OV | CPT code: 99201 | UR Auth #: 1490695

034 - UM Referral review form

Dr. Dan Daly with Montgomery Surgical Associates

Appt date 5/14/05

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

F ... must be Complete and Legible. You must Type or ...

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: 844 - TUTWILER

Site Phone #: 334-514-6269

Site Fax #: 334-514-9559

Will there be a charge? ☑ Yes ☐ No

Sex: ☐ Male ☑ Female

Patient Name: (Last, First) Cleckler, Debra

Alias: (Last, First) Clackler Debra

Inmate # 15956

SS Number 417-80-9985

Date: (mm/dd/yy) 04/12/05

Date of Birth: (mm/dd/yy) 11/26/54

PHS Custody Date: (mm/dd/yy) 08/10/90

Potential Release Date: (mm/dd/yy) 05/23/20

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

John Peasant, M.D.

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☑ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to: Dr Daly

Type of Consultation, Treatment, Procedure or Surgery: Evaluation of Bilat axilla pain, and (R) axilla lipoma

Diagnosis: (R) axilla lipoma

ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset: 50yo c/o Bilat axilla pain. Hx S/P Cholecystectomy.

Results of a complaint directed physical examination: (R) axilla Lipoma - Right tenderness

Previous treatment and response (including medications): Observation & tylenol tab.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required: __/__/__ (mm/dd/yy)

4/13 PK

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

05a - UM Referral review form Dr. Dan Daly with Montgomery Surgical Associates

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Clackler, Debra	Inmate Number:	159516CL
Service Authorized:	Office Visits: General Surgery Consult	Effective Dates:	04/12/2005
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Tutwiler Prison For Women	Contact Name:	Michelle Pope
Authorization Number:	14906957	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section. The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

[illegible]

*** For security and safety, please do not inform patient of possible follow-up appointments. ***

Signature of Consulting Physician: [signature] Date 5-16-05 Time

Reviewed and Signed By Medical Director: [signature] Date 5/17/05 Time

04/14/2005

PHS0298

Appt. Date: Auth #:

NaphCare
Hospital/Consultant Referral Form

Inmate Name: Clincher, Debin AIS#: 159516 Date: 4/4/03

DOB: 11/26/54 Race: W Sex: F Allergies: Codiene

History of working diagnosis (when first recognized, progression of symptoms, physical findings, lab results, current symptoms, current treatments): Fibrocystic Breast Dz (48 yo) - Very dense breasts

SERVICES REQUESTED/PROVIDER: Mammogram

Signature (M.D.):

Pertinent Chronic Conditions/Diagnosis: N/A

DOC Facility: Tutwiler Time Out:

Receiving Facility/Hospital: Adv. Med. Imaging Return Time:

Route of Transportation: (X) ___ Ambulance ___ DOC Van ___ Other:

Date & Result/Last PPD: 1-17-03 20mm Date & Result/Last Chest X-Ray N/A

OFFSITE HEALTHCARE REPORT:

Orders/Recommendations:

Physician: Date: Time:

Notify (Facility): Tutwiler at: # ( ) 514-0819 of patient's discharge.

Advanced Medical Directive: Yes ___ (Attached) No ___

Report called to: (Name/Title): N/A Date:

Signature & Title: N/A Date:

Bill to NaphCare 950 22nd St. N. Suite 825 Birmingham, AL. 35203
Beverly Douglas, R.N. Utilization Review Manager* 205-458-8370 or 1-800-771-0315

Appt. Date: 4/22/03 030310TXR03 Auth #:

NaphCare
Hospital/Consultant Referral Form

Inmate Name: Clackler, Debra AIS#: 159516 Date: 3-6-03

DOB: 11-26-54 Race: W Sex: F Allergies: codeine

History of working diagnosis (when first recognized, progression of symptoms, physical findings, lab results, current symptoms, current treatments): known Fibrocystic breast disease. Dense breasts
Pain @ breast
Needs F/U Comp Mammo

SERVICES REQUESTED/PROVIDER:
Mammograms
Signature (M.D.):

Pertinent Chronic Conditions/Diagnosis: N/A
DOC Facility: Tutwiler Time Out:
Receiving Facility/Hospital: IMT Return Time:
Route of Transportation: (X) ___ Ambulance ___ DOC Van ___ Other:
Date & Result/Last PPD: 1-15-03 20mm Date & Result/Last Chest X-Ray N/A

OFFSITE HEALTHCARE REPORT:

Orders/Recommendations: Report to follow

Physician: Date: Time:
Notify (Facility): Tutwiler at: # ( ) 514-0219 of patient's discharge.
Advanced Medical Directive: Yes ___ (Attached) No ✓
Report called to: (Name/Title): N/A Date:
Signature & Title: N/A Date: